

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

26107

1. PLACE OF DEATH

County..... Registration District No. **781**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **4491 Lee Ave.**) St. **10** (Ward)

2. FULL NAME

Louise Morchen
 (a) Residence, No. **4491 Lee Ave.** St. **10** Ward. (If nonresident give city or town and State)
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

5A. If MARRIED, WIDOWED, or DIVORCED HUSBAND or (OR) WIFE OF **William Morchen**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 17 1879**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 11 13

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **At Home**
 (b) General nature of industry, business, or establishment in which employed (or employer).
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

PARENTS
 10. NAME OF FATHER **Carl Schieber**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
 12. MAIDEN NAME OF MOTHER **Rosina Schieber**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Mrs. Rosina Schieber**
 (Address) **4491 Lee Ave.**

15. FILED **AUG 31 1927** **May B. Starckoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Aug. 30 1927**

17. I HEREBY CERTIFY That I attended deceased from **March 11**, 19**27**, to **Aug 30**, 19**27** that I last saw him alive on **Aug 26**, 19**27** and that death occurred, on the date stated above, at **6:30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis Pulmonary
337 21 (Date) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) **Laryngeal Tuberculosis** mos. 14 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. **Not known**

19. DID AN OPERATION PRECEDE DEATH? **No.** DATE OF _____
 WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Sputum**
 (Signed) **F. W. Rolling**, M. D.
Aug 31, 1927 (Address) **2125 Sedney st**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Friedens** DATE OF BURIAL **Sept. 1 1927**

20. UNDERTAKER **Math. Hermann** ADDRESS **470 9th West Florissant Cor.**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

EMMENT RECORD

